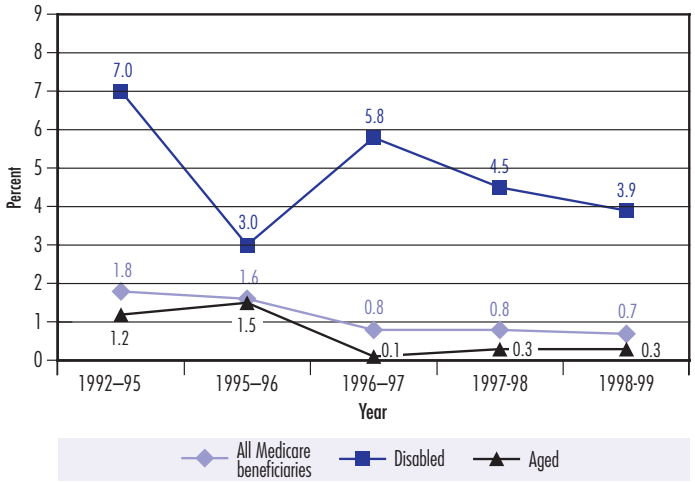
2 TRENDS IN THE MCBS: 1992–1999

THE MEDICARE POPULATION

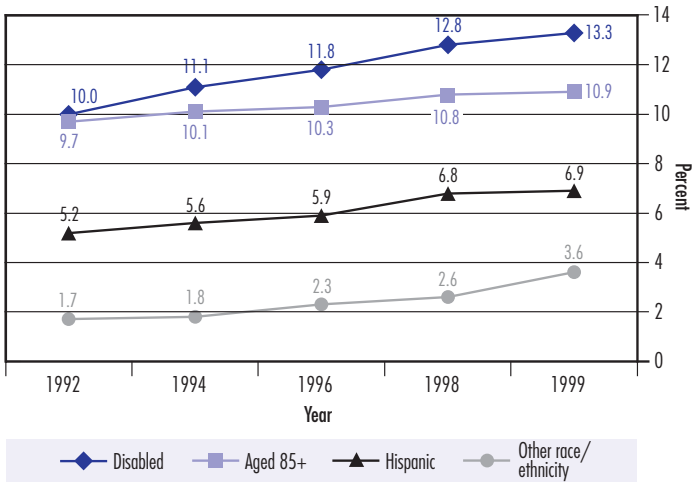
In 1999, the total population of Medicare beneficiaries grew to 40.4 million, up by 0.7 percent since 1998. Disabled beneficiaries numbered 5.4 million, while the aged reached slightly above 35 million. As in the recent past, the number of disabled beneficiaries grew at a much higher rate than the aged (3.9 vs. 0.3 percent) (Figure 2-1).[1] Meanwhile the growth in the aged population inched up from 0.1 percent to 0.3 percent between 1996 and 1998, and remained steady at 0.3 percent between 1998 and 1999 (Figure 2-1).

Figure 2-1. Annual Growth in Medicare Population by Medicare Status, 1992-1999



Certain vulnerable subgroups of the Medicare beneficiaries grew at a much faster rate than the population. Consequently, the composition of the Medicare population continued to become increasingly diverse (Liu and Sharma, 2002) (Figure 2-2). The share of the disabled in the Medicare population continued to rise in 1999, reaching 13.3 percent. Beneficiaries aged 85 or above and those of Hispanic origin continued to rise slightly. The appreciable gain of "other race/ethnicity" as a share of the Medicare population during this period may be misleading, since it reflected a change in the Medicare Current Beneficiary Survey (MCBS) data collection implemented in 1998.[2]

Figure 2-2. Proportion of Selected Groups in the Medicare Population, 1992-1999



PERSONAL HEALTH CARE EXPENDITURES

Personal health care expenditures (PHCE) represent direct consumption of health care goods and services provided by hospitals, physicians, and other sources of medical care and equipment. The MCBS provides estimates of expenditures for Medicare-covered services as well as some relatively expensive services not typically covered by Medicare, for example, nursing home care and prescription medicines (PM). Information on noncovered services fills a large gap in knowledge about beneficiary health care spending. The Centers for Medicare and Medicaid Services (CMS), the primary source of Medicare program data, has claims information for only those services covered under Medicare Part A and Part B.

Estimates of national health expenditures (NHE) are produced annually by CMS.[3] The NHE estimates identify all health care goods and services produced in the U.S. health care market and determine the amount spent on them. The NHE presents a comprehensive picture of national health care spending and

[1]The growth rate of the disabled beneficiaries slowed from 5.8 percent between 1996 and 1997 to 3.9 percent between 1998 and 1999.

[2]In 1998, Centers for Medicare and Medicaid Services (CMS) refined its coding of race by adding the category of *more than one race* to capture data on Medicare beneficiaries with multiracial background. This led to increases in the estimates of the subgroup called *other race/ethnic minorities* in both 1998 and 1999.

[3]National health expenditures include personal health care expenditures, administrative costs, public health spending, and research/construction expenses.

provides information on sources of funding and services consumed by all U.S. residents. Total health care spending by the Medicare population is included in the NHE. The NHE report serves as a valuable frame of reference for policymakers to track trends in the health care industry.

In 1999, the NHE exceeded $1.2 trillion, marking a growth of 5.6 percent from 1998 (Heffler et al., 2001). This continued the relatively low growth trend in recent years. The PHCE share of gross domestic product (GDP) remained steady at 13 percent from 1993 to 1999. In spite of nearly 37 percent growth during this period in NHE (in nominal dollars), the relative stable share of NHE in GDP was largely due to moderate to strong growth in GDP, low economy-wide inflation, high employment rates, increased enrollment in managed care, and the deceleration of growth in Medicare spending resulting from the implementation of the Balanced Budget Act (BBA) (Cowan et al., 2001). However, 1999 also witnessed faster growth in NHE compared with 1998 and was expected to be followed by accelerations in health care costs in 2000 through 2002 (Levit et al., 2002).

PHCE by Medicare beneficiaries exceeded $381 billion in 1999, while the non-Medicare population spent $677 billion (Figure 2-3). Although the Medicare population consisted of only 14.5 percent of the total U.S. population, it consumed 36 percent of national health care resources. Per capita PHCE for the Medicare population was $9,447 in 1999, more than 3 times the amount for the non-Medicare population (Figure 2-4). However, in recent years, Medicare beneficiaries' annual growth in per capita PHCE was considerably lower than that of the non-Medicare population, 2.8 percent versus 8.2 percent in 1999 (Figure 2-5).[4]

PHCE by Medicare beneficiaries revealed two distinct trends between 1998 and 1999, that is, maintaining low overall growth (3.5 percent) and yet showing signs of accelerating growth. The primary factor contributing to the low growth was the BBA effects

Figure 2-3. National Personal Health Care Spending, 1992-1999

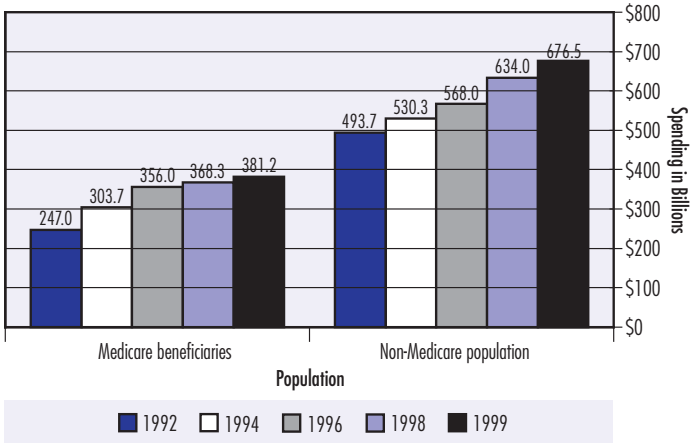
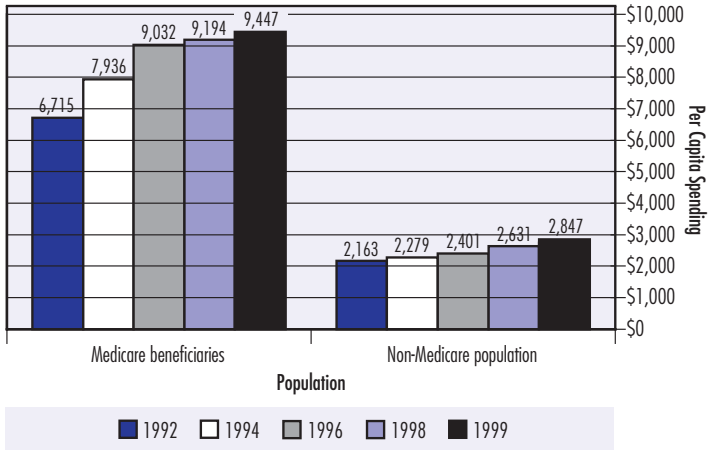


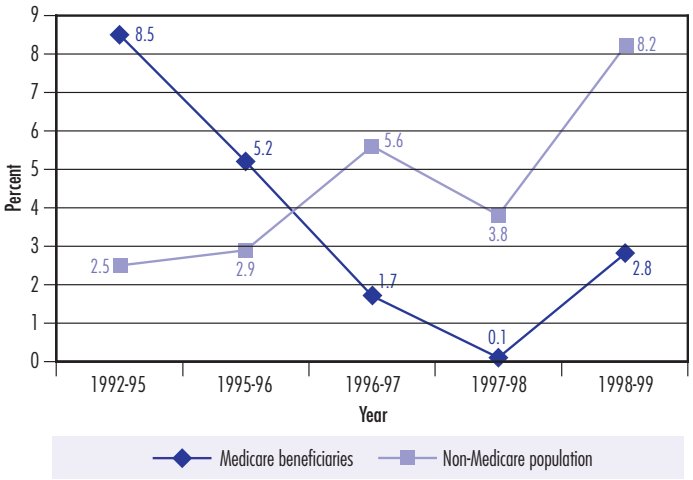
Figure 2-4. Per Capita Spending on Personal Health Care, 1992-1999



of changing payment systems for both home health and nursing home care facilities, and the consequent nearly flat growth in Medicare spending (1.5 percent growth compared with 1998). Other major factors contributing to the low growth in Medicare beneficiaries' PHCE included the Federal Government's efforts to combat fraud and abuse in the Medicare program. The continued

[4]Population and national health expenditure estimates for 1999 come from data published by CMS, Office of the Actuary, in 2001, while estimates for 1998 come from data published by the same source in 2000.

Figure 2-5. Annual Growth in Per Capita Spending on Personal Health Care, 1992-1999



growth of enrollment in Medicare managed care also contributed to the declining or sometimes negative growth rates in Medicare funding.

In spite of lingering low growths in the late 1990s, PHCE by Medicare beneficiaries began to indicate signs of a "growth spurt" between 1998 and 1999. Annual growth rate during this period (3.5 percent) more than tripled that of the previous period (0.9 percent). Both macro economic factors as well as Medical-specific factors explained the accelerations in the growth. Economy-wide, the late 1990s witnessed booming prosperity and substantial growth in income, which in turn stimulated consumption of all services and goods, including health care services. In the medical industry, provider costs increased as insurers were unable to negotiate increasing price discounts and more employment provided more health insurance for the Americans (Heffler et al., 2001).

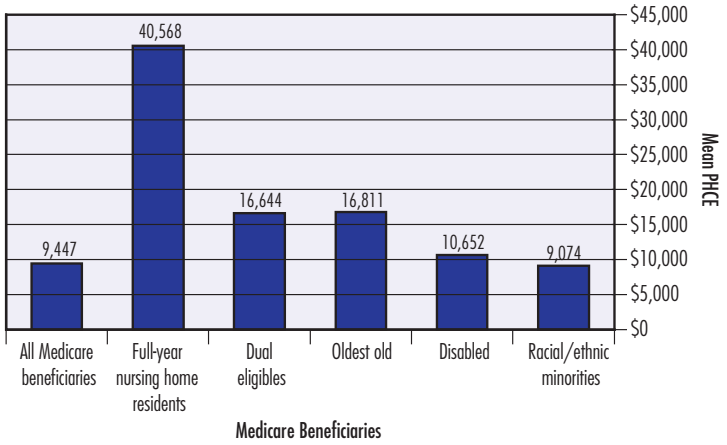
More specific reasons tied to the upturn in the growth of PHCE by Medicare beneficiaries included more spending by private health insurance (PHI), increasing by 19.5 percent between 1998 and 1999, and faster growth in inpatient, ambulatory,[5] and PM spending.

VULNERABLE POPULATIONS AND THE BBA IMPACT

Certain groups of Medicare beneficiaries, often referred to as vulnerable populations, continued to show higher per capita PHCE in 1999. They included full-year nursing home residents,[6] the oldest old, the Medicare and Medicaid dual eligibles (DEs), and the disabled (Figure 2-6).[7] At the same time, other vulnerable groups, such as racial/ethnic minorities, started to show PHCEs lower than the average level of Medicare beneficiaries.

A noteworthy trend that surfaced in the 1999 data was that all vulnerable subgroups indicated a fall in their per capita PHCEs as compared with 1998, except for the full-year nursing home

Figure 2-6. Per Capita Personal Health Care Expenditures by Selected Groups of Medicare Beneficiaries, 1999



[5]Ambulatory care includes medical provider/supplier (MP) and outpatient hospital services.

[6]Their room and board expenses considerably increased their average PHCE.

[7]The subgroups presented in this figure are not mutually exclusive.

residents. Among these subpopulations, the hardest-hit groups seemed to be the DEs and the disabled.[8] Figure 2-7 shows that during 1999, these two groups experienced large declines in their overall per capita PHCE and mean spending on all major types of services, with the exception of mean PM spending. In comparison, other beneficiaries increased their mean spending, except for home health care where all the groups showed substantial reductions.

Racial and ethnic minority groups also appeared to be disproportionately affected by the BBA. Figure 2-8 shows Medicare beneficiaries' mean PHCE by ethnicity, for pre- and after-BBA years. All racial and ethnic minority groups showed declines in mean PHCE since 1997, the implementation of the BBA, whereas White Non-Hispanic was the only group that was not significantly affected.[9]

These numbers suggest that certain vulnerable groups, such as the DEs, the disabled, and racial and ethnic minorities, were disproportionately affected by the BBA. While the overall per capita PHCE increased in 1999 for the Medicare population, the fact that average PHCE dropped for these vulnerable groups warrants further investigation, to ensure that these groups did not encounter additional access barriers brought by the rippling effects of the BBA.

Figure 2-7. Annual Growth Rates in Per Capita Spending on Personal Health Care Services by Medicare Beneficiaries, 1998-1999

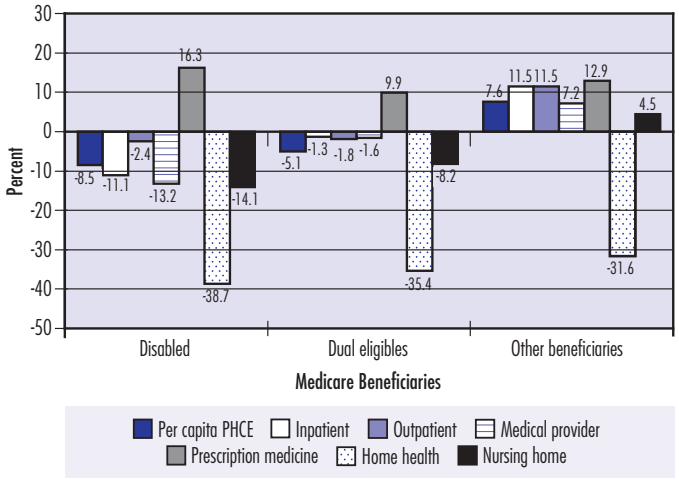
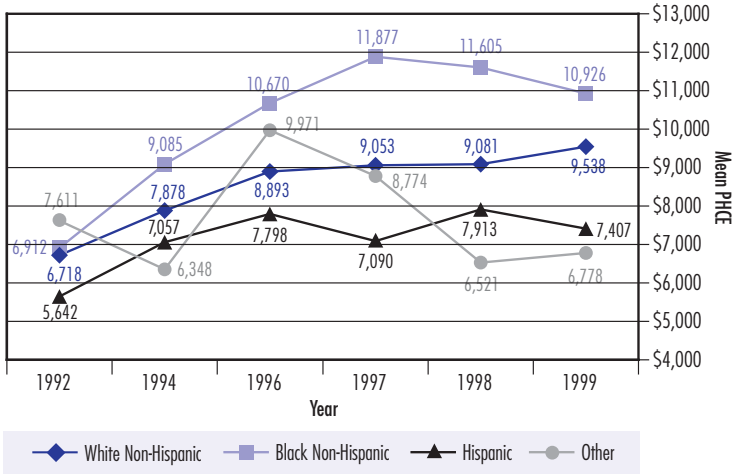


Figure 2-8. Mean Personal Health Care Expenditures by Medicare Beneficiaries, by Ethnicity, 1992-1999



FUNDING SOURCES

The non-Medicare and the Medicare populations exhibited distinctive funding patterns of their PHCE (Figure 2-9).[10] Most of the PHCE by the non-Medicare population were financed by private sources, including primarily PHI (45.7 percent) and out-of-pocket (OOP) payments (16.8 percent).[11] Public funds,[12] mainly from Medicaid, consisted of only 19.3 percent. In contrast, approximately two-thirds of Medicare beneficiaries' PHCE was financed by public sources, even though this share showed declines in recent years (Figure 2-10). In 1999, Medicare funded 53 percent of Medicare beneficiaries' PHCE and Medicaid funded 11.7

[8] These two subgroups are not mutually exclusive. Although these two groups overlapped substantially (32 percent of the DEs were the disabled beneficiaries), they were different enough to make them distinctive groups.

[9] The substantial drop observed in the mean PHCE by the *other* subgroup might be attributed to the impact of the BBA and recoding of the race variable implemented in 1998, when MCBS started to allow the coding of "more than one race" and collapse this group under *other race/ethnicity*.

[10] To achieve comparability between the Medicare and non-Medicare populations, *Other Private Payments* in NHE was collapsed with *Other Public* to become *Payments From Other Sources*.

[11] In this sourcebook, discussions on private sources are limited to PHI and OOP payments.

[12] Discussions on public sources are limited to Medicare and Medicaid payments.

Figure 2-9. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries and the Non-Medicare Population, 1999

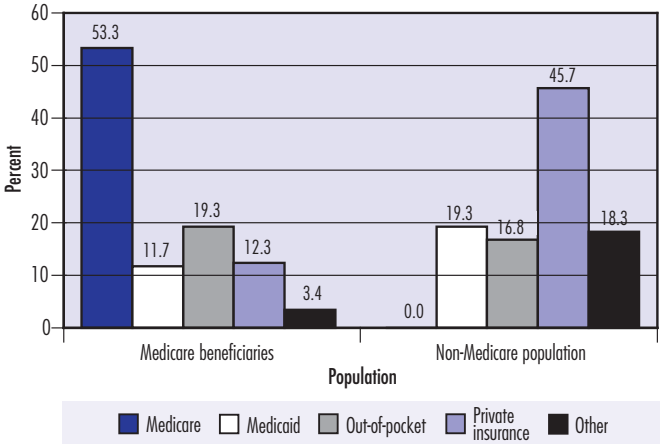
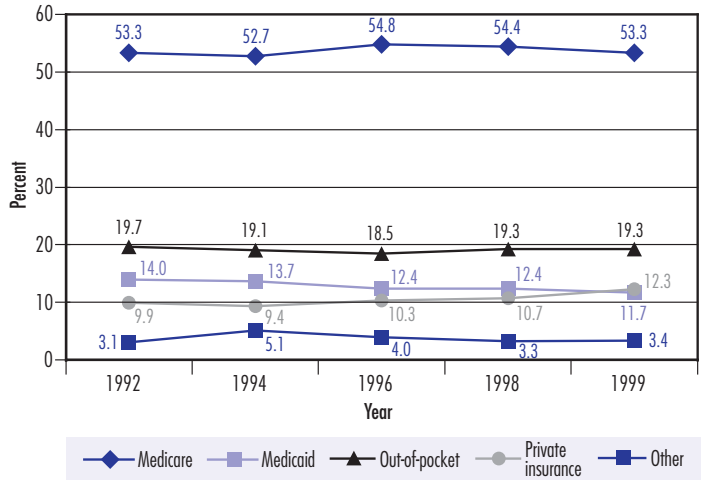


Figure 2-10. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries, 1992-1999



percent. The remainder was covered by OOP payments (19.3 percent), PHI (12.3 percent), and other sources (3.4 percent).

Consistent with trends seen in the NHE accounts (Heffler et al., 2001), growth in public funding for Medicare beneficiaries remained in either low or negative ranges; whereas private funding showed brisk growth since the implementation of the BBA (Figure 2-11). Total Medicare payments in 1999 amounted to $203 billion, a slight increase of 1.5 percent over 1998. Per capita Medicare payment, $5,034, remained almost unchanged from 1998. Medicare's spending pattern on different service types was mixed. Substantial increases were observed in its payments on inpatient and MP care, with respective increases of $4.1 and $4.6 billion. At the same time, sizeable reductions were seen in its payments on home health, long-term nursing home, and skilled nursing facility (SNF) care, respectively -$3.9, -$2.0, and -$0.9 billion.

In addition to factors discussed earlier leading to reductions or low growths in Medicare payments, tightenings in the Medicaid program in recent years also explained declines in public funding.

Unlike the emerging trends in Medicaid enrollment and expenditures seen in the overall Medicaid program (Ellis et al., 2000; Smith et al., 2002), the Medicaid coverage of the elderly and disabled Medicare beneficiaries did not see much expansion, neither in enrollment nor in expenditures. In fact, the size and proportion of Medicare's DE population remained fairly stable in the past 5 years, close to 7 million Medicare beneficiaries (17 percent). Likewise, Medicaid spending on this population, from 1996 to 1999, showed either low or negative growth. In 1999, total Medicaid expenditures of the DEs' PHCE amounted to $44.5 billion, representing a 2.1 percent decline from the previous year.

Per capita PHCE for the DEs showed a negative growth since 1997 (Figure 2-12). For the second consecutive year, per capita PHCE for

Figure 2-11. Annual Growth Rates of Personal Health Care Expenditures by Medicare Beneficiaries, by Funding Source, 1992-1999

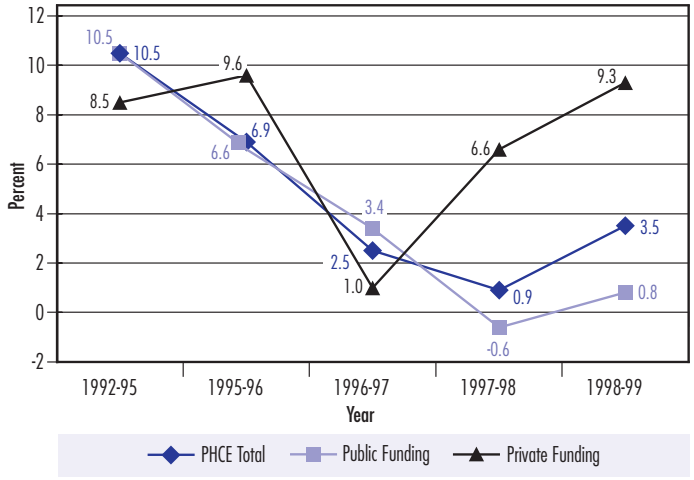
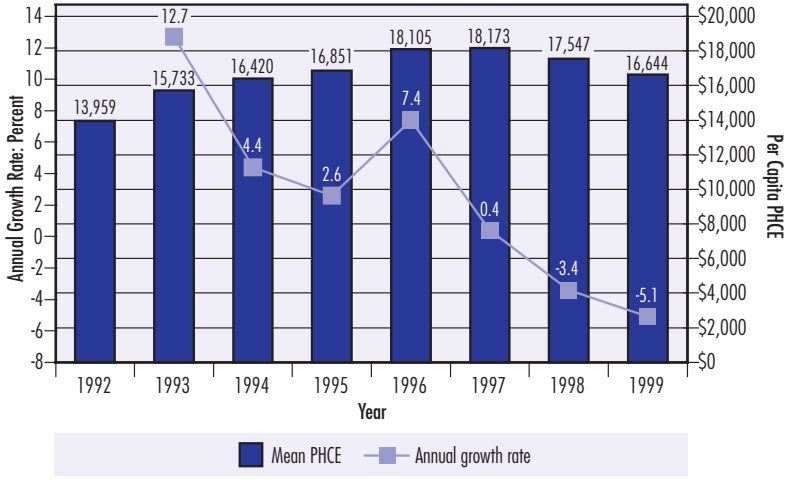
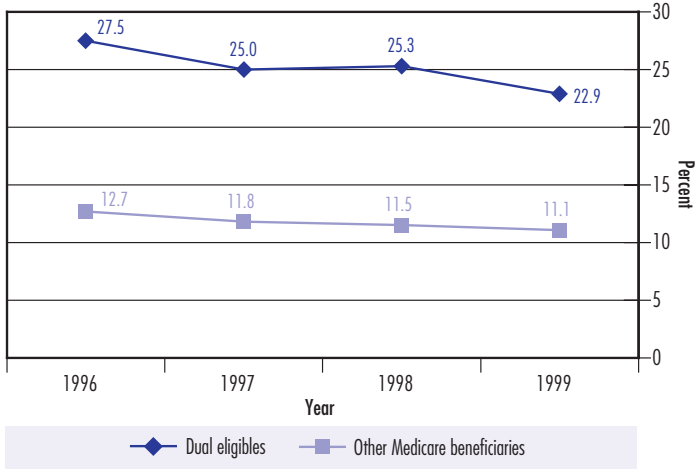


Figure 2-12. Per Capita PHCE and Annual Growth Rate: Medicare and Medicaid Dually Eligible Beneficiaries, 1992-1999



the DE population fell considerably, from $18,173 in 1997 to $16,644 in 1999. Except for PHI (which indicated a growth of 45 percent), all other payment sources reduced their payment levels for the DEs, with Medicare leading the reduction (a 12.5 percent reduction compared with 1997). Since the DE population consumed a large proportion of home health, SNF, and long-term care services, the dramatic cuts in home health care services and other reductions in SNF and long-term care services, as a result of implementing BBA, apparently had a major impact on the utilization of health care services for this population. In 1999, the DE population showed a 34.8 percent reduction in their spending level on home health care services, and a 15.8 percent and a 6.4 percent decrease, respectively, in their SNF and long-term care expenditures. These reductions were considerably larger than those seen in the Medicare population as a whole. Figure 2-13 shows that for the noninstitutionalized DE population, home health user rates declined sharply after the BBA, whereas for other Medicare beneficiaries the decline was much smaller. Likewise, similar trends

Figure 2-13. Home Health User Rates Before and After BBA for Noninstitutionalized Medicare Beneficiaries by Medicaid Eligibility Status, 1996-1999



could be discerned for nursing home user rates (Figure 2-14), where considerable declines were shown only for the DE population.

While public funding declined for Medicare beneficiaries, private funding, specifically PHI, grew briskly during this period (Figure 2-11). The annual growth rates of PHI surged in 1999 to 19.5 percent, representing the second consecutive year of fast growth. In light of strong economic growth and a tight labor market that prevailed in the late 1990s, a greater number of workers had access to PHI coverage. Moreover, under the managed care backlash, a larger number of workers chose less restrictive, more costly options than private HMOs (Cowan et al., 2001). Data on noninstitutionalized Medicare beneficiaries revealed that increased PHI expenditures were observed across all major service types in 1999. Inpatient hospital care showed the largest growth ($2.8 billion), a 42 percent rise from 1998. Outpatient and PM spending also showed substantial increases, 35 percent ($2.4 billion) and 15 percent ($1.7 billion) growth, respectively, from 1998. These large increases might reflect backlashes partially resulting from the tightening of Medicare reimbursement and coverage policies.

Aged and disabled community residents showed distinctive patterns of funding sources compared with nursing home residents (Figure 2-15). For aged community residents, Medicare financed 64.1 percent of total PHCE, while OOP (16.3 percent) and PHI (14.9 percent) payments contributed much of the remainder. Disabled community residents also funded their PHCE primarily with Medicare payments (52.3 percent), along with sizeable contributions from PHI (17.8 percent) and OOP payments (14.1 percent). The financing structure remained basically the same for these two groups compared with 1998, with the difference that Medicare's share dropped and PHI's share crept up. For full-year nursing home residents, Medicaid and OOP payments financed larger shares of their PHCE, at 43.0 and 32.3 percent, respectively; whereas Medicare funded only 17.8 percent, showing declines from 1998.

Figure 2-14. Nursing Home User Rates Before and After BBA by Medicaid Eligibility Status, 1996-1999

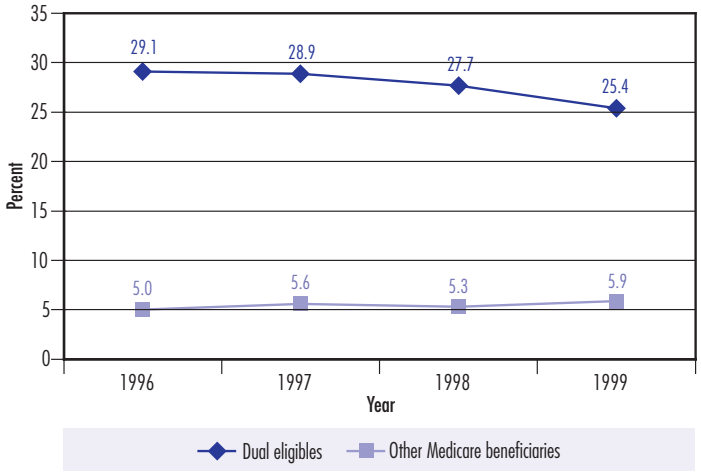
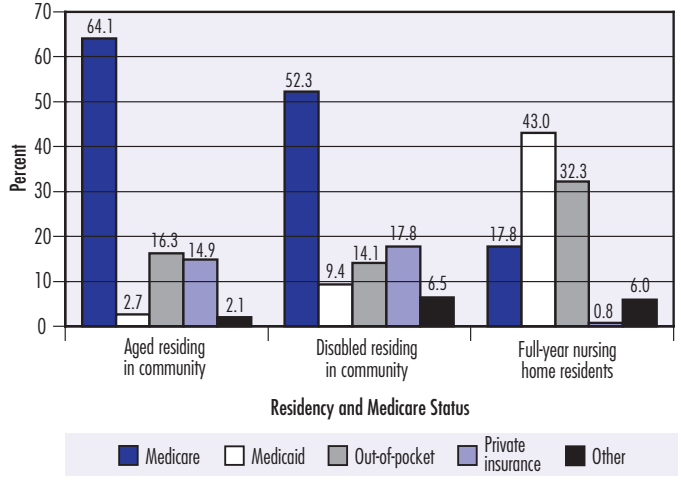


Figure 2-15. Sources of Funds for Personal Health Expenditures by Residency and Medicare Status, 1999



PHCE BY SERVICE CATEGORY

Even though overall PHCE by Medicare beneficiaries showed slow growth in 1999, data on different service types revealed divergent trends. Spending levels on inpatient, ambulatory, and PM services increased. Growths in inpatient and ambulatory spending, $7.7 and $6.1 billion, respectively, contributed more to increased PHCE than PM growth ($4.6 billion). On the other hand, spending on nursing home and home health services declined $2.3 and $4.1 billion, respectively.

As in previous years, spending for inpatient and ambulatory services continued to account for more than 60 percent of personal health care expenditures by Medicare beneficiaries in 1999 (Figure 2-16). In 1999, the share of inpatient spending in PHCE rose from 27.9 percent to 29 percent, reflecting a rapid annual growth of 7.4 percent (Table 2-1). The user rate of inpatient hospital services increased by about 1 percent among noninstitutionalized beneficiaries since 1996 and reached a new high of 20.4 percent in 1999, representing over half a million additional inpatient service users compared with 1996 (8.0 percent increase) (Figure 2-17 and 2-18). Total inpatient stays by noninstitutionalized Medicare beneficiaries were estimated at 13.5 million, also representing a historical high. The MCBS data seemed to suggest that even though mean expenditures for inpatient services did not show significant differences, the surge in the overall spending level of inpatient services was mainly attributed to increased users.

Table 2-1. Annual Growth Rate of Spending by Selected Service Type, 1992–1999

	1992–95 (%)	1995–96 (%)	1996–97 (%)	1997–98 (%)	1998–99 (%)
Inpatient Hospital	6.8	5.0	3.3	-4.1	7.4
Ambulatory	11.1	4.7	3.4	5.4	4.9
Physician/Supplier	10.4	4.4	1.8	5.5	4.2
Outpatient Hospital	13.2	5.5	7.9	5.3	6.5
Prescription Medicine	10.0	14.5	10.5	20.6	13.9
Home Health	24.2	6.7	-8.1	-25.4	-32.1
Nursing Home	12.1	9.0	0.0	-0.5	-2.6
Long-term Care	10.0	5.5	-2.8	1.5	-1.6
Skilled Nursing Facility	34.7	33.9	15.8	-9.8	-7.8

Figure 2-16. Proportion of Personal Health Care Spending by Medicare Beneficiaries, by Selected Type of Service, 1992-1999

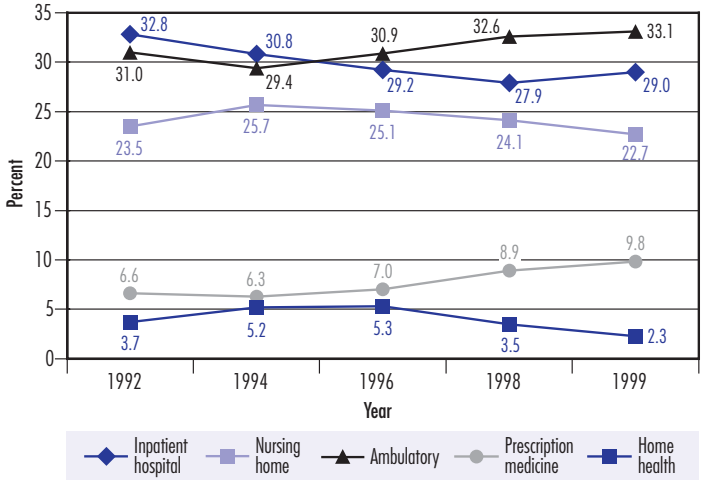


Figure 2-17. Inpatient Service Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-1999

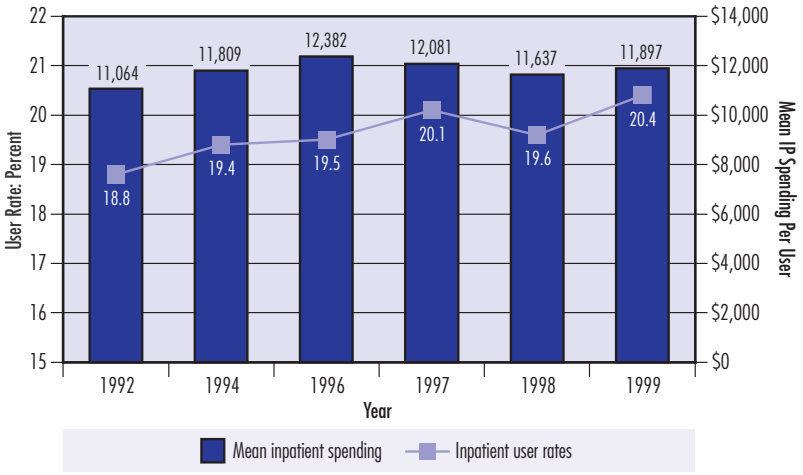


Figure 2-18. Estimated Number of Users of Inpatient Hospital Service and Inpatient Stays Among Noninstitutionalized Medicare Beneficiaries, 1992-1999

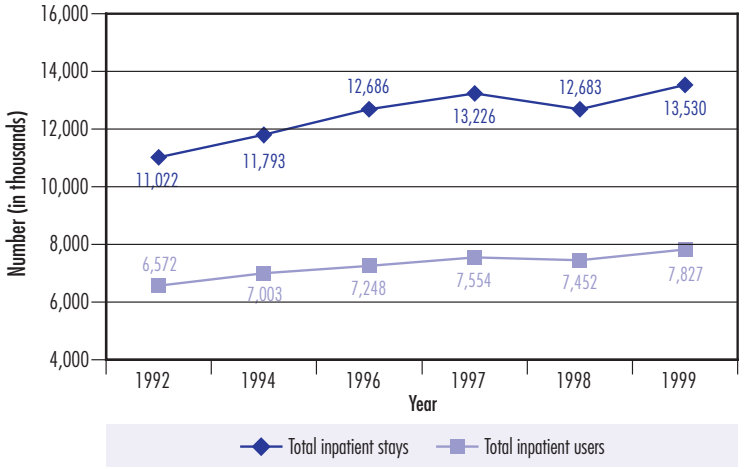


Figure 2-19. Physician Service Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-1999

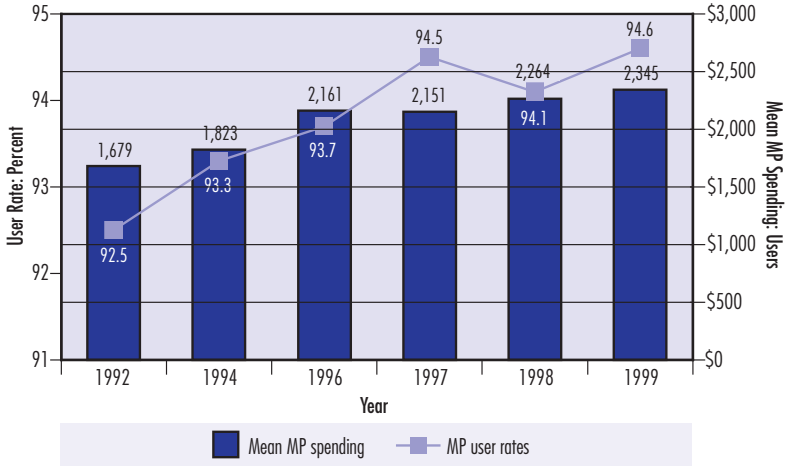
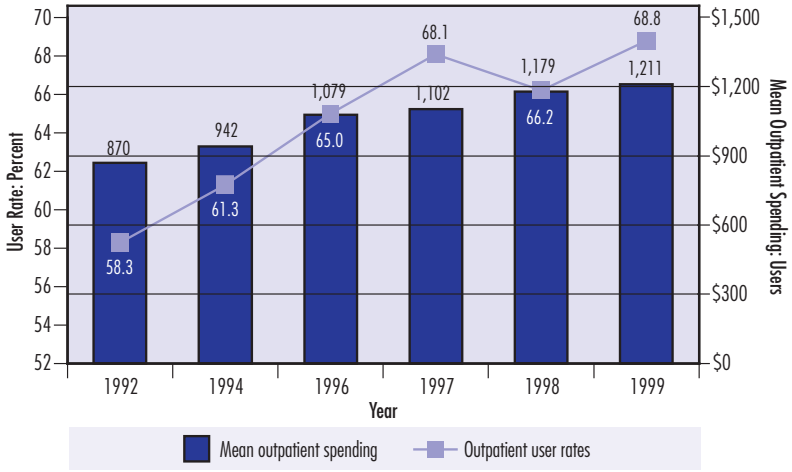


Figure 2-20. Outpatient Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-1999



Increases in inpatient spending were largely shared by Medicare ($4.1 billion) and PHI ($2.7 billion). PHI's overall payments on inpatient services in 1999 increased by 42 percent from 1998.

At the same time, MP and outpatient user rates rose to their highest levels ever in 1999, 94.6 and 68.8 percent, respectively (Figures 2-19 and 2-20), which partially explained the increases in the overall spending levels of ambulatory services. On the other hand, mean spending for users did not show much increase. All the growth in MP spending was absorbed by Medicare payments and all the increase in outpatient spending by PHI. The surge in inpatient and ambulatory care utilization may suggest that Medicare beneficiaries might have switched to inpatient and ambulatory care as a substitute for other types of short- or long-term care in response to the tightening in Medicare's home health and SNF reimbursement policies (U.S. General Accounting Office, 1999).

In 1999, the growth rate of prescription medications spending ranked at the top, at 13.9 percent (Table 2-1). PM's share of Medicare beneficiaries' PHCE increased from 8.9 percent to 9.8 percent, representing a net increase of $4.6 billion. Continuing its rise since 1992, average prescription spending for users doubled in

Figure 2-21. Prescription Medicine Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-1999

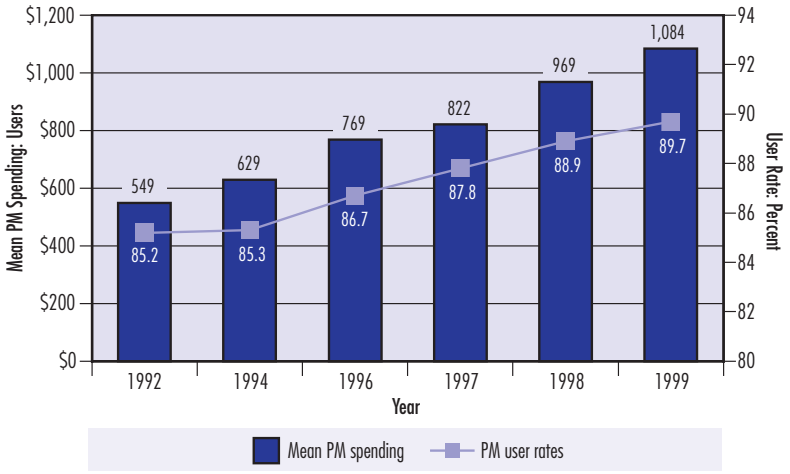
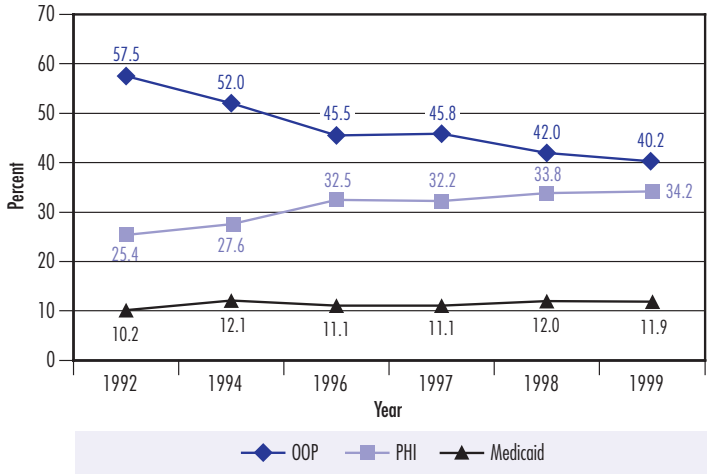


Figure 2-22. Distribution of PM Spending by Major Sources of Payment for Noninstitutionalized Medicare Beneficiaries, 1992-1999

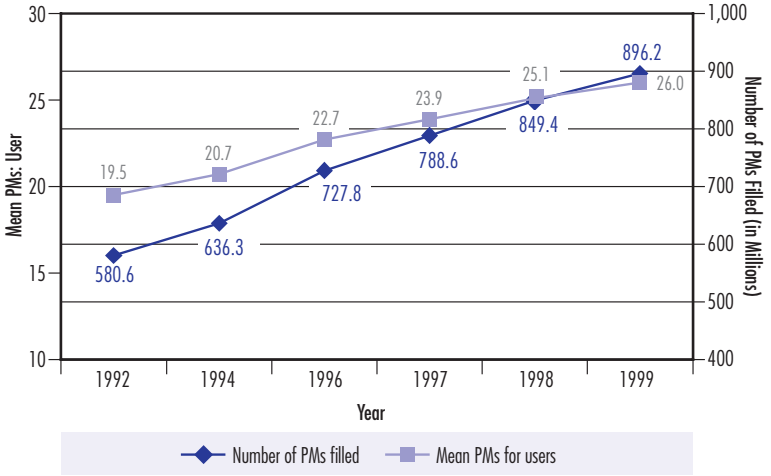


the past 7 years, reaching $1,084 (in nominal dollars) by 1999 (Figure 2-21). Double-digit growth in prescription drug spending, evident since 1994, was attributed to a number of trends. Since PHI and OOP were the major sources of payment of PM expenditures (covering 75 to 83 percent of PM spending), greater coverage of prescription drugs through third-party insurers and the resulting reduction in consumer OOP expenses served to induce greater consumer demand. Data on noninstitutionalized Medicare beneficiaries indicated that from 1992 to 1999, OOP's share of total PM spending declined from 58 percent to 40 percent; whereas PHI's share increased from 25 percent to 34 percent. On the other hand, Medicaid's share of PM showed slight increases (Figure 2-22).

Increased user rates and greater intensity of use also fueled growth (Cowan et al., 2001). Among noninstitutionalized Medicare beneficiaries, total PMs filled increased from 581 million in 1992 to 896 million in 1999 (Figure 2-23), representing a much faster growth rate than the population rate of growth. The average number of PMs filled by users also increased from 19.5 in 1992 to 26 in 1999.

Other factors tied to fast growth included the rising cost of drug prices, in particular, brand-name drugs. It was found that the

Figure 2-23. Trend of PM Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-1999



majority, that is, 80 percent, of the most frequently used PMs by the elderly consisted of brand-name drugs. Prices of these brand-name drugs showed the steepest climb, often much higher than the overall inflation rate (Families USA, 2002).

In response, many third-party payers have adopted measures to slow the rapid ascent in drug spending. For example, some used pharmaceutical benefit managers to negotiate discounts from manufacturers. By 1999, nearly 70 percent of managed care plans used three-tiered prescription drug plans to encourage the use of less expensive or generic drugs (Heffler et al, 2001).

In contrast to the rising trend seen in inpatient and ambulatory care, spending on nursing home and home health care showed decreases in 1999, -2.6 and -32.1 percent, respectively (Table 2-1), largely the impact of the BBA cost containment provisions. As a result, the nursing home share of total PHCE declined in 1999 from 24.1 percent to 22.7 percent, along with the share for home health services from 3.5 percent to 2.3 percent (Figure 2-16).

The observed declines in nursing home spending by Medicare beneficiaries was the outcome of reductions in both long-term nursing home care and SNF care spending, -$1.2 and -$1.1 billion, respectively. This mainly reflected cuts in Medicare payments to SNF and other hospital-based services, arising from the BBA-mandated Medicare prospective payment system (PPS). Total Medicare payments on nursing home and SNF care services decreased by 20 percent from 1998, representing $2.9 billion. At the same time, the drop in 1999 was also a consequence of "reallocation of Medicaid funding from institutional care to less costly home and community-based services" (Cowan et al., 2001). Over the past years, Medicaid overall payments for both long-term nursing home and SNF care by Medicare beneficiaries showed either negative or low growths.

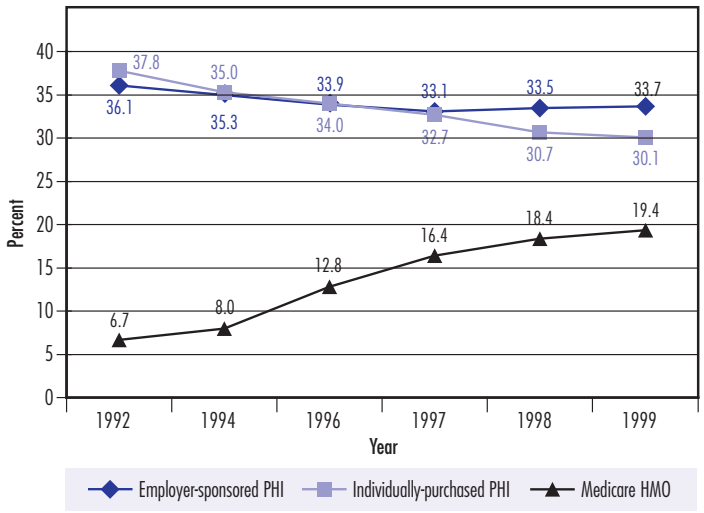
Dramatic declines in home health spending continued in 1999 for the third consecutive year for Medicare beneficiaries. In 1999, home health care spending on Medicare beneficiaries plummeted by more than 32 percent, representing $4.1 billion. The bulk of the contractions, $3.9 billion, were caused by reduced Medicare payments on home health care compared with 1998. In addition to intensified government efforts to detect fraud and abuse, as well as the home health industry's reaction to increased oversight, greater financial constraints imposed by the BBA and provider responses to them led to huge reductions. For instance, limits on the extent of coverage and new payment regulations substantially reduced levels of utilization and spending. Average home health spending for users dropped to $1,543 in 1999, only about half as much as the 1996 level.

INSURANCE STATUS

In the past few years, parallel with the booming employment market in the late 1990s, employer-sponsored PHI appeared to expand its coverage among working adults. Medicare beneficiaries, though largely out of the work force, also seemed to enjoy the benefit of the booming economy. The rate of employer-sponsored PHI among Medicare beneficiaries apparently halted its downward slide and showed slight increases in 1998 and 1999 (Figure 2-24). Approximately 34 percent of noninstitutionalized beneficiaries were covered by employer-sponsored PHI.

On the other hand, individually-purchased PHI continued to decline among Medicare beneficiaries in the past years (Figure 2-24). The steady declines of individually-purchased PHI could be attributed to multiple factors, in particular, rising cost of PHI premiums, eroding benefits of individually-purchased PHI, and low cost and added coverage accompanying Medicare HMOs. In response to rapid cost increases, private insurance premiums grew faster in 1999 than mid-1990s, thus making private coverage

Figure 2-24. Trends of Private Health Insurance and Medicare HMO Coverage for Noninstitutionalized Medicare Beneficiaries, 1992-1999



increasingly more expensive (American Association of Retired Persons, 2002). As a result, more than 50 percent of Medicare beneficiaries left individually-purchased PHI plans and enrolled in Medicare HMOs (Murray and Eppig, 2002).

Parallel to the trend of the declining rate of individually-purchased PHI, enrollment in Medicare HMOs expanded by close to 200 percent since 1992 among Medicare beneficiaries, reaching 19.4 percent of the noninstitutionalized Medicare population in 1999. Medicare HMOs often made available additional benefits of health care services that were not covered by Medicare fee-for-service, such as PM coverage, at considerable lower cost than PHI. Nevertheless, growth in Medicare HMO enrollment evidently decelerated in recent years. This might reflect the recent instability in the managed care market, as some Medicare HMO plans withdrew from selected service areas or terminated their contracts in order to curtail losses. It might also be a result of some health plans requiring beneficiaries to pay an increasingly larger share of costs while reducing benefits at the same time (Medicare Payment Advisory Commission, 2001).

The proportion of Medicare beneficiaries having certain types of supplemental insurance remained stable in the past several years, as the percentage of fee-for-service (FFS) only beneficiaries stayed at close to 10 percent.

SUMMARY

In 1999, the Medicare population grew slightly, maintaining the steady low growth rate since 1996. The Medicare population continued to become more diverse as the proportion of subgroups of beneficiaries, such as the disabled, those aged 85 or above, and racial/ethnic minorities, expanded over the years.

Medicare beneficiaries consumed a disproportionately larger share of national health care resources. In 1999, per capita PHCE of the Medicare population was more than 3 times as much as that of the non-Medicare population. In 1999, Medicare beneficiaries' PHCE maintained low overall growth, yet revealed signs of accelerating growth.

Similar to 1998, primary factors contributing to the low growth were the BBA impact on Medicare payments, the Federal Government's efforts to combat fraud and abuse, and continued growth of enrollment in Medicare managed care. The acceleration in the growth rates was probably fueled by the booming economy in the late 1990s, increased health insurance provided by employers, and rising provider costs in the medical industry.

Since 1997, the BBA's impact on Medicare payments has been evident as the overall level of Medicare expenditures showed either negative or low growth. Medicare's reductions targeted certain types of services, for example, home health and SNF care. Since

vulnerable subgroups of the Medicare population used more of these services, they seemed to have born disproportionately the brunt of the BBA impact. In contrast to the increase in per capita PHCE among the overall Medicare beneficiaries in 1999, mean PHCE of all the vulnerable subgroups declined from their 1998 level, except for full-year nursing home residents. Among these groups, Medicare/Medicaid dual eligibles and the disabled appeared to take the hardest hit.

In 1999, the share of public funding for Medicare beneficiaries' PHCE declined; whereas the share of private funding, specifically PHI, increased. This reflected the low or negative growth of public funding, both Medicare and Medicaid, in the past few years. Among sources of payment, Medicare beneficiaries primarily rely on Medicare and Medicaid, while the non-Medicare population relies mostly on private insurance. In 1999, beneficiaries residing in communities indicated that PHI funded a rising share of their PHCE. For full-year nursing home residents, a rising share was covered by Medicaid and OOP payments.

The distribution of Medicare beneficiaries' PHCE for selected health care services continued to shift in the past several years, primarily as a result of the BBA and changes in the health care market. In 1999, shares of PHCE for inpatient hospital, ambulatory, and PM services increased, whereas the share of PHCE for nursing home and home health services declined. Substitution of services might take place as substantial reductions were observed in Medicare and Medicaid payments on home health and nursing home care. Consequently, Medicare beneficiaries may have increased their use of inpatient and ambulatory services as user rates peaked in 1999 for these services.

Due to lower OOP cost and more intense utilization of newer, more expensive medications by Medicare beneficiaries, the growth in PM spending was the highest among all types of health services. PM's share of PHCE continued to rise. Increasing PHI payments for PM services fueled the fast growth in PM consumption.

Over the past several years, Medicare's payment policy has been "caught in an action-reaction cycle" (Medicare Payment Advisory Commission, 2001: xv). These policy mandates apparently shaped, more than other factors, the access and utilization patterns of health care services for Medicare beneficiaries. The 1998 and 1999 MCBS data substantiated that BBA apparently achieved its intended goal in curtailing Medicare expenditures. However, certain subgroups of Medicare beneficiaries seemed to bear more of the impact. The Balanced Budget Refinement Act (BBRA), passed in November 1999, moderated some of the BBA's effects. It called for a delay in previously mandated BBA Medicare payment reductions to providers and increased Medicare per beneficiary payment limits for home health services. The BBA's effect on access to health care for Medicare beneficiaries, in particular the vulnerable populations, warrants further investigation.